# Patient-Centered Medical Home Qualification Standards

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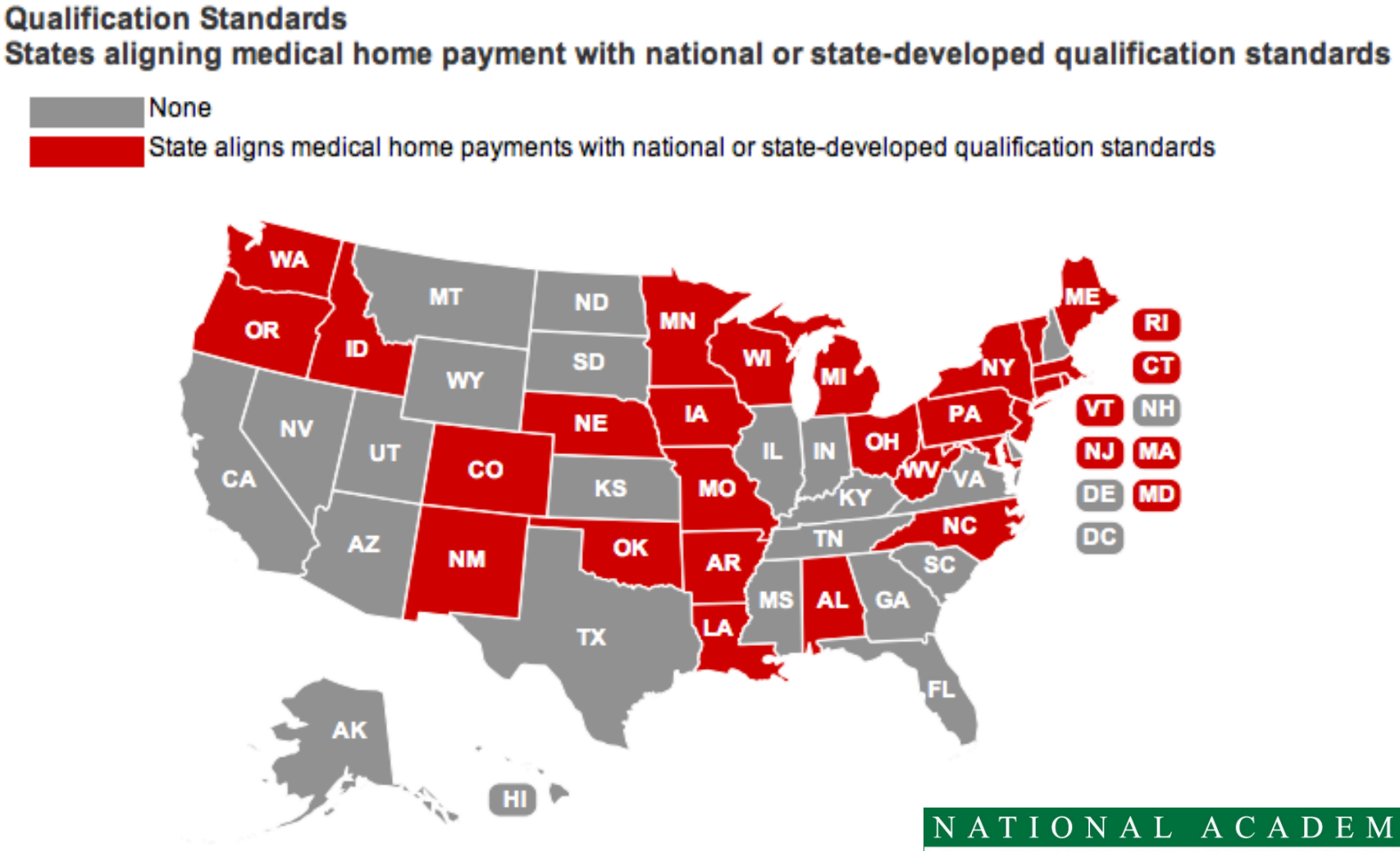
# Why qualification standards?

- What is a medical home?
- Raising the bar for primary care practices

# 27 States Tie Payments to Qualification Standards

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Screenshot from: http://nashp.org/medical-home-patient-centered-care-maps/index.html - x4-tab

# Types of PCMH Qualification Standards

- National Standards
- State-Developed Standards
- Hybrid
- Practice tools

# National Standards

- NCQA PCMH Recognition
- Joint Commission PCMH Certification
- URAC PCMH Achievement
- AAAHC Certification and Accreditation

# National Standards Crosswalk

| | NCQA | Joint Commission | URAC | AAAHC |
|---|---|---|---|---|
| **Overview** | 27 elements across 6 categories (6 must-pass elements) | 43 elements across 12 categories (all standards required) | 28 elements across 7 categories (7 must-pass elements) | 8 core standards and 19 additional standards based on services provided by practice |
| **Tiers** | 3 (based on score) | Pass/Fail | 2 (based on electronic health record) | Certification (lower)/Accreditation (higher) |
| **Electronic Health/ Medical Record Requirement** | Not for recognition, but some standards would require use | Use of information technology required, but not necessarily EMR | Only for "Achievement with EHR Designation" | No, although electronic data management is encouraged. |
| **Length** | 3 years | Up to 3 years | 2 years | Up to 3 years |

Crosswalk adapted from/Additional information available at: http://www.pcdc.org/assets/pdf/09-09-11-crosswalk-of-medical-home-stds.pdf; www.ncqa.org; www.jointcommission.org; www.urac.org; www.aaahc.org.

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# NCQA PCMH 2011 Content and Scoring

| PCMH1: Enhance Access and Continuity | | Pts |
|---|---|---|
| **A.** | **Access During Office Hours**** | **4** |
| B. | After-Hours Access | 4 |
| C. | Electronic Access | 2 |
| D. | Continuity | 2 |
| E. | Medical Home Responsibilities | 2 |
| F. | Culturally and Linguistically Appropriate Services | 2 |
| G. | Practice Team | 4 |
| | | 20 |

| PCMH2: Identify and Manage Patient Populations | | Pts |
|---|---|---|
| A. | Patient Information | 3 |
| B. | Clinical Data | 4 |
| C. | Comprehensive Health Assessment | 4 |
| **D.** | **Use Data for Population Management**** | **5** |
| | | 16 |

| PCMH3: Plan and Manage Care | | Pts |
|---|---|---|
| A. | Implement Evidence-Based Guidelines | 4 |
| B. | Identify High-Risk Patients | 3 |
| **C.** | **Care Management**** | **4** |
| D. | Manage Medications | 3 |
| E. | Use Electronic Prescribing | 3 |
| | | 17 |

| PCMH4: Provide Self-Care Support and Community Resources | | Pts |
|---|---|---|
| **A.** | **Support Self-Care Process**** | 6 |
| B. | Provide Referrals to Community Resources | 3 |
| | | 9 |

| PCMH5: Track and Coordinate Care | | Pts |
|---|---|---|
| A. | Test Tracking and Follow-Up | 6 |
| **B.** | **Referral Tracking and Follow-Up**** | **6** |
| C. | Coordinate with Facilities/Care Transitions | 6 |
| | | 18 |

| PCMH6: Measure and Improve Performance | | Pts |
|---|---|---|
| A. | Measure Performance | 4 |
| B. | Measure Patient/Family Experience | 4 |
| **C.** | **Implement Continuously Quality Improvement**** | **4** |
| D. | Demonstrate Continuous Quality Improvement | 3 |
| E. | Report Performance | 3 |
| F. | Report Data Externally | 2 |
| | | 20 |

**Must Pass Elements

# NCQA PCMH 2011 Scoring

6 standards = 100 points
*6 Must Pass* elements

NOTE: Must Pass elements require a ≥ 50% performance level to pass

| Level of Qualifying | Points | Must Pass Elements at 50% Performance Level |
|---|---|---|
| Level 3 | 85 - 100 | 6 of 6 |
| Level 2 | 60 - 84 | 6 of 6 |
| Level 1 | 35 - 59 | 6 of 6 |
| Not Recognized | 0 - 34 | < 6 |

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

# NCQA PCMH Recognition

- Next update scheduled March 2014
  - Further integrate behavioral health
  - Focus on resource stewardship
  - Encourage sustained commitment to continuous quality improvement and PCMH transformation
  - Expanded emphasis on care coordination and transitions
  - Encourage shared-decision making and incorporate the patient, family, and caregivers into care planning
  - Maintain alignment with Meaningful Use and encourage information exchange

# State-Developed Standards

- Some states have built their own requirements.
  - Oregon (Patient-Centered Primary Care Homes)
    - 6 Core Attributes
      - Access, Accountability, Comprehensiveness, Continuity, Coordination/Integration, and Patient/Family Centeredness
    - 3 Tiers
      - **Basic:** Foundational Structures and Processes
      - **Intermediate**: Demonstrated Performance Improvement and Additional Structures and Processes in Place
      - **Advanced:** Population Management and Accountable for Quality, Utilization and Cost
    - Accepts NCQA – although these practices need to submit additional information specific to the state program.

# New York's Health Home Standards

- Partnership model with a lead health home agency partnering with additional providers in the community ("downstream providers").
- Standards:
  - Comprehensive Care Management: Creation, documentation, and execution of an individualized, patient-centered care plan.
  - Care Coordination and Health Promotion: Assigned care manager for each patient.
  - Comprehensive Transitional Care: Prompt notification of admissions, discharges, and transfers.
  - Patient and Family Support: Care plan must be accessible to patients and families; must also reflect patient preferences and show cultural competency
  - Referral to Community and Social Support Services: Identification of and collaboration with community-based resources and social support services.

# Hybrid Standards

## "NCQA-Plus"

### Maine

- Requires NCQA + 10 additional standards
  - Select examples:
    - Behavioral health integration
    - Population risk-stratification and management
    - Team-based care
    - Inclusion of patients & families in redesign
    - Focus on cost containment and waste reduction in QI activities
    - Integration of health IT
    - Connection to community resources

### Missouri

- As part of primary care health home program, required qualifying practices to achieve higher scores for certain standards.
- Example: NCQA requires a score of 50% to meet a "must-pass" element. Missouri required the practice to score 75% – requiring the practice to meet additional factors within the standard.

# Massachusetts' Primary Care Payment Reform Initiative (PCPRI)

- Requires NCQA Level 1 within 24 months, plus additional core competencies, HIT, and care management standards.
  - Patient-centeredness, multi-disciplinary care teams, population management, care management for high-risk patients, and patient-self management support
- Comprehensive Primary Care Payment (CPCP) Tiers based on the level of behavioral health services in practices.
  - **CPCP Tier 1:** Practice provides no behavioral health services
  - **CPCP Tier 2**: Practice provides minimum set of behavioral health services
    - Includes full-time on-site behavioral health provider onsite
  - **CPCP Tier 3:** Practice provides maximum set of behavioral health services
    - Includes 0.2 FTE psychiatrist on-site, 24/7 access to behavioral health services, and basic behavioral health services included in EHR

# Key Takeaways

- Qualification standards provide assurance to payers
- Qualification standards can be meaningful or they could merely be a paperwork exercise
- Becoming qualified as a medical home is hard work
- Plenty of opportunities to customize standards to meet your delivery system goals

# For More Information


**Please visit:**

- www.nashp.org
- http://www.nashp.org/med-home-map
- http://www.nashp.org/state-accountable-care-activity-map
- www.statereforum.org
- www.pcpcc.net

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